IAATO Sample Passenger Medical Questionnaire

Antarctic Expedition Cruising

No sophisticated medical facilities are available in the Antarctic. Although our vessel carries a qualified physician and a limited infirmary with basic medications and equipment, we ask that you complete this confidential medical report so that our shipboard physician is fully aware of your medical condition and needs – and can better care for you aboard.

This expedition is intended for persons in reasonably good health. Passengers who are not fit for long trips for any reason, including disability, heart or other health condition, are advised not to join the tour, which would entail an unreasonable risk to your health and safety of you and others on the expedition. Should any such condition become apparent, we reserve the right to decline to accept or retain you or any other passenger at any time during the trip.

Please return this completed form with registration, including Part III, Medical Advisor's Opinion. It must be received by time of final payment. This is part of our obligation for self-sufficiency under the terms of the Antarctic Treaty System. In addition, you are advised to carry your own regular medications, which may not be available aboard.

Passengers are further advised that medical evacuation, if available, is expensive, and that we strongly recommend that you have medical insurance that will reimburse you for this cost. The areas being travelled in are very remote and where medevacs are possible can take up to 2 days and in some cases (such as South Georgia) medevacs are impossible, as the area is out of the range of helicopters and/or does not have landing strips.

Part I: Traveler's Health Statement

I attest that I am in good general health, and capable of performing normal activities on this expedition. I further attest that I am capable of caring for myself during the expedition, and that I will not impede the progress of the expedition or the enjoyment of others aboard. I understand that this expedition will take me far from the nearest medical facility and that all travelers must be self-sufficient. With that understanding, I certify that I have not been recently treated for, nor am I aware of, any physical or other condition or disability that would create a hazard to myself or other members of the expedition.

Name _____ Date _____

Signature _____

Expedition _____ Departure Date _____

Part II: Traveler's Medical Information

Date of Birth: _____ Blood type (If known): _____

Evaluate your general health:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Evaluate your physical condition/stamina:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Have you taken out medical insurance? ☐ Yes ☐ No

1 This Sample Medical Questionnaire is provided to IAATO Members for implementation and use by their onboard physicians and/or medical staff. IAATO does not review the travelers' responses to the Medical Questionnaire and does not make any determination as to whether a particular traveler is fit for travel to Antarctica. Fitness for travel determinations are within the discretion of the Member and its onboard physician/medical staff. IAATO Members are not authorized to make any express or implied statements to their travelers that IAATO is receiving and/or reviewing the medical responses and making determinations of fitness for travel.

Do you have, or have you had in the past 5 years, any of the conditions below?

Condition	Yes	No
High blood pressure		
Heart/vascular disease		
Heart surgery		
Asthma/bronchitis		
Blood disorder		
Diabetes		
Digestive disorder		
Kidney problem		
Skin problem		
Allergies		
Infectious/ contagious diseases		
Epilepsy/seizures		
Dizziness/fainting		
Loss of consciousness		
Loss of memory		
Balance problem		
Severe headaches		
Ear/nose/throat problems		
Restricted mobility/difficulty walking, use crutches, a walking stick or wheelchair		
Back problems		
Amputation		
Do you have a prosthesis or joint replacement?		
Fractures/dislocations		
Stroke		
Eye/vision problems		
Are you currently pregnant?		

If you answered yes to any of the above, please elaborate below:

Do you have any medical illnesses, disabilities or infirmities that require the regular care of a doctor? ☐ Yes ☐ No

List all medications that you are taking at this time, the dosages and the condition that is being treated.

Medication	Dosage	What are you taking this medicine for?

Have you been hospitalized or had surgery in the last five years? If so, when and for what?

Do you have any drug allergies? If so, what are they?

Do you have any dietary restrictions or food allergies? If so, what are they?

Do you have any other physical or mental limitations, or handicaps not mentioned above?

Who should be contacted in case of emergency?

Contact 1:

Name _____ Relationship _____

Phone Number(s) _____

Contact 2:

Name _____ Relationship _____

Phone Number(s) _____

Part III: Medical Advisor's Opinion

Please give this form along with your itinerary to your personal physician.

Dear Doctor,

Our traveler is planning an expedition cruise to the Antarctic, where sophisticated medical facilities are unavailable. Each vessel carries a physician and a small infirmary. While not strenuous, travelers who participate on excursions must negotiate a steep gangway, get in and out of landing boats with assistance and be capable of walking a short distance over uneven and slippery terrain ashore. The areas being travelled in are very remote and where medevacs are possible can take up to 2 days and in some cases (Such as South Georgia) medevacs are impossible, as the area is out of the range of helicopters and/or landing strips.

We would like to be sure that each of our passengers is in adequate medical condition for the voyage and that our shipboard physician is fully alerted to any potential health problems. Please feel free to contact us at _____ if you have any questions. We would appreciate your evaluation of:

The travelers' overall physical condition:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

The travelers' ability to participate in this expedition and excursions:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please elaborate on any medical conditions that you feel our shipboard physician should be aware of.

Thank you for your help.

Doctor's name	Date	Doctor's Signature
Telephone	**City, State, Country**	**Email**